The Health Care Team

Excellence Need Not Cost More

Relating a Free Clinic's Services to the Patient's Convenience and Feelings

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HIGHLAND GENERAL HOSPITAL is the acute care public hospital facility for Alameda County, which lies on the east shore of San Francisco Bay. The hospital was founded in 1926 and in February, 1970, completed and occupied a new facility containing 313 beds. Adjacent to the hospital is a Mental Health unit consisting of 73 beds and extensive outpatient services. Highland is located in Oakland and, as with most public hospitals, serves a minority and indigent population. Highland Hospital is approved for and has filled its 42 intern positions for many years. There are also 91 residents enrolled in 13 specialties. Highland, like most county public hospitals in the past, was medically run by house staff with the loyal but sporadic services of a large visiting staff. During the past five years many full-time medical staff have been added so that all major services have at least one, and in some instances two, full-time physicians. This has afforded opportunity for a careful analysis of the services offered by the hospital and of the means required to correct the shortcomings of such an institution.

The Problem

The Obstetric and Gynecologic service of Highland Hospital (like most of the specialty clinics) had been established along the traditional lines with essentially two mass clinics—obstetrics on one day and gynecology on another. Three smaller sub-specialty clinics were conducted; namely, Abortion, Gynecologic-Cancer and Endocrinology. No effective appointment system existed and all patients were told to report at 7:30 a.m. The clinic began at 8:30 a.m. and ran until noon for obstetrics and until 4:00 p.m. for gynecology. Nine examining rooms were used and were staffed by the six OB-GYN residents and three interns. Pre-registration for billing was conducted for all clinic patients on the first floor and the OB-GYN patients were then weeded out and directed to the third floor where they would have to register again to obtain a sequential number. Inasmuch as some patients could not be seen until noon, the waiting time could be up to three to five hours. Save for what socializing could be done in the hallways, the waiting period was of no benefit. Irate patients, short-tempered clerks and howling children were the ordinary. From one obstetric appointment to the next, the patient's only recourse to information or advice was handled by the switchboard operator who referred the patient to an already overloaded emergency service. No means of relating with "my doctor" or even "the obstetric clinic" was available because this clinic space was used on the other three and a half days by such other specialties as Dermatology, Allergy

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and Urology. An obstetric patient with constipation would remain in this state until her next obstetric appointment, or else would go to the Emergency Department to vie for attention with approximately 150 daily emergency patients including those with stab and gunshot wounds and those injured in highway accidents.

The Beginning of the End

The first change in the system, undertaken in the Fall of 1969, was to eliminate the pre-registration lines and to stagger the times of appointments. Information for billing and for other needs was obtained all at one time, when the patient arrived. The patient then was directed to a large pleasant waiting room from which she was summoned by intercom to the examining room. During the patient's time in the waiting room, a pre-anounced teaching program was held. It included the showing of films and discussions by nurses, physicians, nutritionists, social workers, and public health nurses, aimed at giving patients supplementation to their original prenatal teaching interviews. Even patients who did not become involved in the discussions were nonetheless exposed to it. This program also showed the human side of the hospital as distinguished from the remoteness that caused patients to say "Highland did this" or "those Highland doctors" or "those Highland nurses." Nonetheless, the clinic continued to run in the same fashion—nine open cubicles with only one layer of cotton drape separating one patient's problems from another patient's initial pelvic examination. Although for shorter periods, absenteeism of doctors (residents) from the clinics continued because of responsibilities they also had for deliveries, emergency surgical operations and coverage of the emergency room consultative service. But one thing was apparent: We had the personnel, the skills, the experience and the patients. All we had to eliminate was the complacency.

The End of the Beginning

During the summer of 1970, a self-contained unit adjacent to the clinic area was accidentally discovered by the OB-GYN Department. This area previously contained clerk-typists who were each assigned a room equipped with a sink, bright lighting and windows. Besides the six rooms, the unit also contained a reception area, a toilet, a laboratory and a work room. Soon after it was discovered, the unit was painted and redecorated and converted into four examining rooms, one consultation room and a waiting room. Daily appointments were made at 15-minutes for two doctors. The doctors assigned to the clinic were a resident and an intern. The resident rotation was of three months' duration, the intern rotation was every three weeks. During the rotation, these physicians had no inpatient or emergency room responsibilities. They did, however, take night calls in rotation. In addition, the area formerly used was abandoned by the OB-GYN Department and the mass clinics that had been conducted there were discontinued. The five remaining residents were then given one afternoon a week to see patients whom they personally scheduled. In general, each of these residents sees eight to twelve patients per weekly session for postoperative observation or for infertility, endocrinologic or other problems. Patients began to relate to a specific physician and continuity of care following hospitalization was more assured. Gynecologic-Cancer and Abortion clinics are still held separately from the "office."

The clinic operates from 8:00 a.m. to 4:00 p.m. weekdays, and patients are given a choice of day and hour. Appointments are made immediately either after the visit or by telephone in the decentralized clinic rather than in the central appointment area. Having two physicians available in the clinic eight hours a day plus a permanent nursing staff has enabled patients to call in and have minor problems handled by telephone. The personnel are able to handle or make a special appointment for problems which cannot wait until the next scheduled appointment. Emergency cases are still handled through the Emergency Department in the usual manner and OB-GYN consultations are available by a physician other than one assigned to the clinic.

Our patient teaching program has been altered in that there are now two prenatal teaching experiences conducted by a full-time OB-GYN nurse coordinator. She does the initial intake of the patient—history, laboratory work and the like—and conducts a class for the pregnant patients. She also conducts La Maze classes in the evening (the first utilization of this clinic building

during other than the usual "county hours"). In the waiting room informational films are shown on a casette film-viewer.

Nursing staff in addition to the OB-GYN nurse coordinator consists of a full-time staff nurse, one licensed vocational nurse, one nurse's aide, one clerk and one half-time registered nurse. In the former set-up, we required 156 hours of fragmented, rotating nursing and aide time. Currently, we use 140 hours of full-time personnel who can establish a continuing relationship with patients. Under the old system, we required the use of four clerks, one each for pre-registration, processing-in, processing-out, and appointments. These functions have been assumed by one full-time clerk who has performed with a courtesy and efficiency not always apparent in the past. All personnel involved initially volunteered for these jobs, and there have been no requests for transfers out. On the contrary, we have had many requests for transfers into the unit.

Results

The waiting time for patients has been reduced to approximately 10 to 15 minutes. We still occasionally find that a chart has been misplaced, but this is not frequent. Patients experienced in the "old system" comment favorably on the changes. Some patient education was required to assure the patients that their appointed time was indeed reserved for them. This helped to decrease the "no shows" and tardiness. The house staff all were pleased with the change. They are receiving a realistic look at office practices and procedures never before offered as part of their training. Clinic teaching is maintained by having the full-time staff come to the clinic frequently to handle problems as they arise. The chief residents are in and out of the clinic all day, helping in consultations and in the training aspects of the program.

The clinic staff has begun to receive amenities previously unknown—cakes, thank-you notes, pictures of newborn infants, cookies and, most gratifying of all, "smiles." With cessation of the mass clinics which tied up the house staff for approximately two full days each week, the remaining staff now has more time for study. Our Medical Records Department reports that chart deficiencies have also decreased with this newfound time for the house staff.

Although we feel we have made great strides since the initiation of the program, only a part of the problem has been tackled. Our "office" needs to be run in the evening and on weekends; baby-sitting services should be made available, transportation to and from the clinic should be more accessible and attitudes throughout the entire institution must be changed. Until all clinics and services in the institution have adapted themselves to the needs and comforts of their patients, we shall continue to operate in a vacuum separate and alienated from the indigent community we serve. We must accept the fact that only with intelligent, concerned and non-bureaucratic leadership can we offer dignified and responsive services. This can be done at less cost and with greater efficiency than in the past, which was represented by less than adequate, fragmented, and crisis-oriented care. The problem is too apparent and real to require further time-consuming and expensive studies.

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NO FOOD BY MOUTH FOR TACHYPNEIC INFANTS

Any infant that is severely short of breath is likely to aspirate oral feedings. . . . Because of the frequency of aspiration in tachypneic infants, I think (particularly when it is an acute process) that oral feedings ought to be withheld and the infant should either be maintained by intravenous feedings or have a feeding tube put down. We repeatedly see tragedies when feedings are given orally in infants who are in fairly profound degrees of respiratory distress. I think this is true regardless of the cause of the respiratory distress.

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